**Local Child Safeguarding Practice Review re Andre**

## Introduction

1. A Local Child Safeguarding Practice Review was initiated in Enfield regarding Andre after the National Child Safeguarding Review Panel responded to the Rapid Review report, submitted on 02.09.2021. At the time of his death, Andre was subject to a Child Protection Plan and to a Youth Referral Order (YRO) with Intensive Supervision and Surveillance (ISS). The Rapid Review was necessitated as Andre had been stabbed to death in a park where he should not have been due to an exclusion requirement as part of this order. At the time of his death, he was wearing a tag, however learning has been identified in that a GPS tag had not been requested as part of this requirement. The Rapid Review had also identified good practice in engagement with this young person and in managing risk and some learning around information sharing, duplication in systems that supported working with young people, and difficulties in re-housing families.

2. The National Panel advised the Enfield Safeguarding Children Partnership regarding further areas of further inquiry to inform learning:

   "*We thought your LCSPR should be proportionate and build on the learning you have already identified through your rapid review and should focus on the two identified areas of learning. In particular, to explore the interaction between diversity and culture and to look at how your newly established adolescent safeguarding service is working and how it impacted on this case".*

3. The National Panel also sent this link to their report on Child Criminal Exploitation "It was hard to escape". The National Panel also noted its own focused activity around the challenges of securing appropriate housing for young people at risk of exploitation or involvement in gang activity as a short-term solution. This had been an issue raised by the ESCP as a result of learning from the Rapid Review.

4. The Rapid Review had also identified that there was merit in exploring further the theme of practice and planning when working with parents with parental mental health in terms of developing the parental capacity to be protective in the life of the young person. Therefore, these three themes, along with adding to any of the learning already identified through the Rapid Review process, are the focus of this review. the learning will be taken forward through the Safeguarding Partnership learning and action planning by the Practice Improvement sub-group.

5. A learning summary was provided for practitioners in the form of an Executive Summary in May 2022 with key findings shared with practitioners, whilst the criminal prosecution of Andre's alleged assailants was pending. In November 2022, a teenager was found guilty of murdering Andre.

## Methodology

6. With the suggested themes from the National Panel as a guide to the next steps for this review, the independent reviewer facilitated several conversations with different practitioners who had worked directly with Andre. The first conversation was held on 24th November, virtually, with a large group (approx. 25) of practitioners, their managers, and strategic leads. Key practitioners who had worked directly with that attended are listed at point 14 below. Also, the child protection chair; a specialist police officer from the exploitation team attended and all staff were appropriately supported by managers in attending the meeting as well as strategic leads for safeguarding.

7. The conversation was structured using the following questions as guidelines:
    i. **What does this case tell us about how we work with culture, diversity, identity:** *what works well? what might we do differently? what needs to change in order to get this area of practice 'right'?*
    ii. **What learning from this case might be useful for the new adolescent safeguarding service?** *Think good practice and what might we need to do differently*
    iii. **Working with parental mental health when working with a parent to help them respond and manage contextual risks to their child?** *what works well? what might we do differently? what needs to change in order to get this area of practice right?*

8. The time allocated to this discussion was perhaps not enough given the complexity and the emotional investment by practitioners when working with Andre and the impact of the tragic ending of his life. Additionally, the conversation was rich and the content very in-depth and to do their practice and experience justice, further conversations were held those who came in to contact with Andre and his family. During December 2021, these included:
    - A meeting with staff at the Pupil Referral Unit (PRU) where he was on roll for two years with the two deputy headteachers; the YOS worker; the YOS psychologist; the YOS head of service, followed by attending weekly assembly at the school with all pupils present.
    - A meeting with the team managers and practice leads in the newly developed Adolescent safeguarding service in the local authority
    - A discussion with the allocated social worker to Andre and his family, now manager of the team working with the family
    - TBA – a discussion with the family GP; adult mental health service [this remains outstanding at the time of writing]
    - The independent reviewer wrote twice to Andre's mother during January 2022 and made contact through two professionals in February 2022 with whom she was currently receiving services from. However, Andre's mother felt she did not wish to engage with this review process.

**The young person**

9. It is essential to preserve the young person's anonymity and that of his family, however the information in this section hopefully gives some insight in to the extent of the working relationships that professionals were able to form with Andre. There was significant detail shared with the reviewer regarding the nature of their relational practice with him. Some detail is also included to reflect the underpinning approach that practitioners emphasised to the reviewer and hopefully emulated in this review: that this is a *"child first, offender second*".

10. Andre was well-liked by those who met him professionally. He was described as having *"a presence": there was something about him".* He was also described as "*a pleasure to work with*", *"polite and never rude".* Andre was mixed-heritage, from two diverse ethnic backgrounds. He was said to have been proud of his ethnicity. He was described as a "*real family man"* by one practitioner and very protective of his sibling.

11. Some members of this extended family, who lived in another part of the UK, were involved throughout in his life and were regarded as positive and protective factors for him. A grandparent had died when Andre was in his early teens. This loss was felt to have been a turning point and had had a negative impact on Andre in terms of his presentation.

12. Andre's father is not thought to have been involved in his life, which may have led to a sense of rejection for Andre. It was reflected upon by some professionals that not enough had been done to engage with Andre's father as a possible protection from the risk of exploitation and gang involvement, however this may have been led by Andre's own view of his father. Andre lived with his mother, a sibling and sometimes his mother's partner in a very small flat. Andre's girlfriend, who he met at his school, sometimes stayed with them. Practitioners suggested that the family's flat was very small, and that the situation had often felt *"oppressive"* for Andre. Often at the weekend, his mother and younger sibling went elsewhere, leaving Andre alone. Some practitioners suggested that Andre did not seem to like mother's partner much and perhaps felt rejected when his mother went to stay with her partner.

13. During the last 18 months of his life, Andre had significant professional involvement with professionals, both within the criminal justice system and the child protection system. Prior to his death he was subject to a Child Protection Plan and to a Youth Referral Order (YRO) with Intensive Supervision and Surveillance (ISS). This sentence was felt to have been a rapid escalation in severity given that he had been involved in the criminal justice system for a relatively short period. An observation was made that the opportunity to work in the way that practitioners did with Andre only came with this level of involuntary intervention, however Andre took the opportunity and did engage in a meaningful way. Professionals included:
    a. An allocated Youth Offending Worker after he was place on the YRO
    b. An allocated C and F social worker who worked with him and his mother and sibling

c. A police officer from the Exploitation/ Gangs service.
d. A specific intervention with the YOS psychologist
e. Contact with the YOS nurse
f. At the PRU there were 4 key staff members who Andre gravitated towards and who were in daily contact with him which he was in attendance – two of who are the deputy head-teachers.
g. Gangs and mentoring worker from a third sector organisation, including activities such as football

14. The details of his offences which led to this sentence can be found in the Rapid Review however they related to carrying a weapon and possession of Class B drugs. Practitioners were clear that Andre did not use cannabis or even smoke cigarettes. As part of his ISS, he had been excluded from a specific area in the city, primarily for his own safety. Andre was not known to be involved in 'county lines' and was felt to be on the periphery of a gang he associated with.

15. Prior to this period, Andre had not been known to statutory services, and had not stood out until his exclusion from mainstream school when he was 14. An attempt at rehabilitation to mainstream school had not worked, resulted with him returning to the PRU. It was noted by practitioners that Andre felt he had no friends however observed that he had friends at the PRU but had also made friends in the mainstream school who were regarded as hard-working and high achievers. At the PRU, Andre a range of activities – staff observed that he enjoyed playing cards and games but also often sought solitude and like to read books intended for a younger audience, perhaps as a way of comforting himself.

16. The YOS worked with Andre on a daily supervision timetable which included educational activities provided within his full-time attendance at the PRU as well as pro-social activities such as helping at the food bank, which Andre was said to have enjoyed very much. He was subject to a 12-hour night-time curfew and wore a tag. Learning identified after his death and since them implemented for other young people was that Andre's safety could have been increased by GPS tracking of his tag – he was fatally injured in the area that he had been banned from visiting.

17. Andre had a close relationship with his girlfriend who he had met at the PRU. The relationship appears as caring but intense, and when his mental health deteriorated, it was suggested that this relationship became less 'healthy' in terms of how Andre behaved towards her.

**Part One: Working with Andre's culture and diversity.**

18. Safeguarding professionals involved in the Rapid Review were curious about why Andre was drawn to carrying a weapon and to being part of a gang from another part of the city. They were also concerned as to how Andre's mother seemed at times to be protecting him and at other complicit in enabling him to access situations which professionals felt compromised his safety. A useful challenge made was that to understand this more required more information about how practitioners made sense

of this family's behaviours as representative of their culture and what was that culture? The learning arising is considered alongside some key publications. The following definition of culture was offered to the learning event held on 24.11.2021. Using this definition as a starting point, the review sought to understand what extent practitioners understood, responded to, and worked together using a culturally competent approach.

*"Culture can be understood as the social heritage of a group, organised community or society. It is a pattern of responses discovered, developed, or invented during the group's history of handling problems which arise from interactions among its members, and between them and their environment. These responses are considered the correct way to perceive, feel, think, and act, and are passed on to the new members through immersion and teaching. Culture determines what is acceptable or unacceptable, important or unimportant, right or wrong, workable or unworkable. It encompasses all learned and shared, explicit or tacit, assumptions, beliefs, knowledge, norms, and values, as well as attitudes, behaviour, dress, and language….*

*…Culture provides a context that made the behaviour of individuals understandable. "The only way in which we can know the significance of the selected detail of behaviour is against the background of the motives and emotions and values that are institutionalised in that culture" (*Benedict, R, *Patterns of Culture,* 1934, published in referenced document) [1]

19. Another recent publication by Her Majesty's Inspectorate of Probation (HMIP:2021) is also relevant in the analysis it offers around the disproportional over- representation of black and mixed heritage boys in the criminal justice system [2] and their experience of racism which often results in the pathway that leads them into that system. As suggested by the HMIP research: *"The skills, understanding, knowledge and integrity of the worker and the relationships they form with black and mixed heritage boys are the most important factors in supporting and promoting meaningful and effective engagement."* The ethnicity of the worker was not deemed to be so important, however, the evidence suggests that practitioners that acknowledge racism as one of the 'problems' which shapes a young person's responses are demonstrating these factors. The practitioners in this review spoke of "*honesty, integrity and transparency"* in their work with Andre and his peers as the basis for successful engagement.

20. Andre worked with several practitioners who, during the conversations held, evidenced their understanding of his complex lived experience including the structural and individual racism he experienced; their willingness to explore the difficult aspects of this with him in very skilled and nuanced ways; and their capacity to meet his needs

[1] Practice Guidance for safeguarding children in minority ethnic culture and faith (often socially excluded) communities, groups and families. Section 5.1 Accessed 03.01.2022 http://iscp.gg/CHttpHandler.ashx?id=110456&p=0

[2] The experiences of black and mixed heritage boys in the youth justice system. A thematic inspection by HM Inspectorate of Probation October 2021. Accessed https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/10/The-experiences-of-black-and-mixed-heritage-boys-in-the-youth-justice-system-thematic-report-v1.0.pdf

for care and nurture. How they did this and continue to do so with other young people is described below.

21. Over the course of time, Andre had 'self-selected' 4 members of staff at the PRU who became trusted adults for him. One discussed how they had worked individually with Andre to reflect on his mixed-heritage identity, on how his peer group saw him and how more generally the world perceived him. This appears as an on-going exchange – this member of staff offered this opportunity flexibly, often in the context of engaging Andre in a practical activity or helping in the school. Andre was "*exploring his masculinity and trying to work out where he fitted in*": this staff member emotionally supported him through that process. Different staff developed their own individual styles of relationship with him. They spoke about sometimes having to take a risk in how they responded to him, needing to recognise his demeanour when Andre arrived in the morning. Andre had been very clear when he started at the PRU that he did not like or appreciate any appropriate physical touch however one staff member recalled that he would sometimes take a risk with that and was important to do so as part of his connection with Andre.

22. This staff member reflected upon the experience he shared with Andre of being a black man, and how this led to instances where the police would stop them unfairly. They would discuss the bigger societal inequalities through to managing racist micro-aggressions in interactions with others. It was observed that Andre was developing an understanding of how he would be treated because he was black, echoing the comment in the HMIP research*: the boys demonstrated a degree of fatalistic acceptance that they are treated differently based on their ethnicity. Police stop and search was discussed in this context and, while it was evident that this was a stressful experience, it had also become normalised and an accepted part of everyday life.*[3] We cannot speculate as to whether Andre *'accepted'* this, but it does appear as though he was being helped within this positive relationship to navigate these challenging experiences.

23. Practitioners identified that racism had encroached in to and influenced his attachment relationship with his mother as the primary caregiver. Practitioners said that Andre's mother had indicated that her family had wanted her to terminate the pregnancy with Andre because his father was black. Practitioners reflected their analysis that Andre's identity had been conflicted and that he had sensed rejection from infancy resulting in his low self-esteem. Andre was not sure yet of his identify but seeking something and the practitioners spoke of working with him to try to help him construct his self so that he was confident in who he was. Like many young people this might result in experimenting. For Andre, being associated with a gang may well have driven in part by seeking his identity.

24. The practitioners from the YOS and the school understood the complexities of Andre and his peer group. Andre sometimes maintained that he had no friends, staff felt that due to his trust issues and fear of rejection, he may not have invested in peer

[3] Ibid, p21

relationships. Staff reflected on the intricacies of peer group dynamics and the techniques they used to work with peers who were all receiving services from statutory agencies. Several examples were shared of the (frequently deployed) technique of using third-party scenarios to support exploring dilemmas with young people: Andre's friends approaching trusted practitioners with their concerns, describing hypotheticals regarding an anonymous friend's difficulties, as Andre did regarding other young people. Practitioners would then talk through with the young people, resolving problems and helping them finding solutions, as well as identifying the positive in young people's concern for their friends. One practitioner emphasised that friendship is a powerful and positive resource in the face of serious youth violence and should not be seen as a threat, suggesting that friendships between groups of black and mixed heritage boys should be understood with more nuance than through a negative lens which criminalises those friendships.

25. Staff worked hard to understand his perception of the fear Andre felt. Andre's reality was that he lived in one area but stated he had affiliations to a gang from another part of the city. The roots of this fear were tangible for professionals – Andre had been involved as a victim in some fear-provoking incidents and it was acknowledged that to get to school, Andre had to cross an area where another gang were known to meet. Youth offending practitioners were clear they knew Andre's anxiety about even stepping out of his front door: they worked to manage the risks posed in different geographical contexts. They also ensured the safety of young people who came to their offices by making it their business to use professional intelligence and information from young people themselves to understand what is happening on the streets, in schools, in young people's networks and friendship groups; and in gangs – i.e., in all their contexts, each of which had their own cultures and rules. The Head Teacher at the PRU noted that she ensures that all staff are kept up to date with this contextual information/ intelligence as relevant to the need to safeguard each pupil.

26. Often Andre arrived at school seeking solitude. Again, practitioners were able to evidence the need to work at this pace of the young person. One staff member would sit outside with him on the sports area, sometimes in silence, if that was what was required, or would walk with him. Practitioners understood the intensity of his living arrangements as an unwanted aspect of his culture: the experience of deprivation, lack of choice and a poverty of opportunity. Andre had nowhere to escape to when his home was crowded. One of the school staff was emphatic in describing how substandard and overcrowded housing was the most significant factor for many of the young people in the school and describe how young people spoke of the inevitability of choosing to go out on to the street, rather than be cooped up. But to be out on the street comes with risk and so some young people also chose to carry a knife for safety.

27. Practitioners worked with Andre to develop different strategies to overcome his fear and poor mental health, acknowledging the different aspects of safety e.g., emotional, physical, or locational. It was recognised that he needed respite from the pressure of his life and so his order was varied so that he could go to stay with relatives. When went to visit the maternal extended family he described "feeling

free", but he then returned to the city. The YOS psychologist recognised in how psychological interventions could be provided in flexible and different ways – understanding and intervening with mental health and illness to not only with a focus on the individual but the influence of and interaction with their context and environment upon their emotional wellbeing. This intervention allowed Andre to reflect and explore his behaviour as a response to the adversities which formed his responses - that were his culture.

28. Professionals note that Andre had stated he would only live until he was 17 – but it was hard to understand if he had meant he would commit suicide. When he was depressed, Andre had questioned what the purpose of life was and that he felt there was 'no purpose'. The YOS psychologist recalls encouraging Andre to articulate where he had learned that fact – that there was no purpose, thus allowing him to explore some of the challenges and losses in his life. During sessions they discussed the 'pros and cons' of being alive and explored and spoke openly about his poor mental health. They also spoke of music and ethnicity which were central to Andre's life. The psychologist observed that an everyday experience of racism and a sense of purposelessness was at the forefront of many young people's poor mental health.

29. Andre had experienced racism at mainstream school and had been treated differently from white peers, however his experience of the PRU was different. The PRU's embedded trauma-informed approach is aimed at tackling the commonly faced problems of the young people that attend of exclusion and of poor life opportunities to interrupt the development of a young person's culture as violent and harmful. The setting recognises the trauma of being excluded from the mainstream education system and why it happens. Not re-creating this is central to their offer to young people and the PRU works to ensure that the 'failures' experiences are not internalised and that negative events, often driven by bias in the system, should not define them.

30. At the PRU, enrichments days are often celebration events which are based around celebrating the positives of the young people's culture. The approach is visible throughout the school with posters, artworks, displays celebrating the unique culture symbols, practices, patterns and rituals of all of the young people that attend. The PRU also recognises that, for some children, there are not the supportive structures around them and that to recover from exclusion the school provides emotional support as central to their response and also in the preventative short-term interventions on offer for younger pupils on the edge of exclusion.

31. It was reported that Andre and his mother felt let down by the housing department in the area that they had planned to move to and felt as though they were turned down because they did not fit. This was compounded by additional hurdles in the housing application process department which delayed the plan to move Andre out of the city, which then led to his mother not pursuing the option to move. One practitioner spoke of structural racism that the family had experienced and the challenge for him as a professional in that Andre's family deemed the practitioner as

not able to make a difference with their housing need. The family perceived him as *"the same as us"* i.e., as also struggling with racism as a black person.

32. Understanding Andre's unique culture and experience of diversity was key to managing the extra-familial safeguarding risks to Andre and posed by him, especially where his perspective on that risk was opposite to that of professionals. Professionals worked to understand the *'pull factors'* , the attraction of the gang that Andre was affiliated with. The gang provided clear rules and consistency in expectations in a way where other contexts did not – for example the difficulties of a teenager living with a parent who had challenging behaviours due to mental illness. It provided something which Andre recognised and wanted to be part of. Andre was clear that he felt safe when he went to the place where the gang, he associated with was based. Another draw for Andre was the music and the fashion. One practitioner suggested that the gang should not be considered ' a *black* culture' , but a *'young person's* culture' that offers alternatives to boys and young men who did not have alternative role models such as fathers who would give the innate sense of belonging that was sought. Andre was very guarded in his conversations in terms of sharing information about what he did and where he went but practitioners describe using third party scenarios with Andre to examine the risks and rewards of being affiliated to the gang.

**Key practice pointers in working with culture and diversity:**

33. There are some brief pointers which appear to underpin the approach to working with culture and diversity with young people such as Andre.

- Ensuring that the young person's voice is central to the intervention - *"doing with, not to".*
- Be transparent and honest about your role and statutory duties and who you work alongside e.g., courts, police, but also create safe spaces for young people to talk
- Being informed about the young person and the contexts they move through – what is happening now that is relevant.
- Working in a strength-based risk informed way with young people – risk is everywhere, everyday; as are resources and protective influences, and sometimes risk and resource can be found in the same place.
- Communicating in real time with practitioners in partner agencies around new or relevant information which informs risk management
- Reflect in real time with colleagues about the young person, events, changes and what they might mean.
- Reflect with the young person about their experience.
- Between the YOS worker and the psychologist, they spoke of *"passing on the trust"* Andre had in one professional, into the new professional relationship.

**Learning Point: the practitioners in this review demonstrated some excellent practice with Andre. There were many enabling factors support good quality practice – values, the context of practice, leadership, communication, clarity of purpose and approach, experience, skills, personal attributes which this account has only briefly touched upon.**

**Recommendation One: Acknowledging and reflecting upon the elements of good culturally competent and anti-discriminatory practice is and how to embed it in safeguarding practice in Enfield should be a priority and focus for Enfield Safeguarding Children Partnership over the next year.**

**Part Two: Working with parental mental health.**

34. Practitioners observed that the relationship between Andre and his mother seemed more sibling-like than parent-child and enmeshed and complex. Practitioners working with the family noted unpredictable nature of Andre's mother's mood and presentation. Even when Andre's mother sought help from agencies, the communication and engagement often became difficult, with mother responding in a way that was described as 'hostile' and 'aggressive' by practitioners. Whilst practitioners understood this as due to her poor mental health, partly due to mother's explanations for her behaviour, there was not a shared understanding of her mental health diagnosis and how it impacted upon her parenting: the mother had disclosed differing explanations to differing professionals as to what her diagnosis was. Some practitioners did evidence their very detailed understanding of Andre's daily lived experience of his mother's behaviours and described how they sometimes had to mediate over the phone between Andre and his mother. Andre's day at school was observed as 'mirroring' how his morning at home had gone – his mood emulated the pattern of his mother's different moods.

35. One practitioner who worked closely with mother evidenced a well-practiced strategy for supporting mother to engage with services. Some forms of communication were not useful but unannounced visits were, where Andre's mother was found to be less confrontational. Working at the mother's pace allowed this practitioner to access the home to assess the family. Positively, this mother was noted as tending to her children in driving Andre to school or cooking an evening meal every evening. However, whilst acknowledging this as a good basis for change in families, the focus on simply achieving visits or acknowledging a parent's capacity to provide basic physical care may have fallen short of gripping the more complex and harmful aspects of the inconsistency or unpredictability in meeting a child's emotional needs.

36. Practitioners found that mother sometimes swung between being authoritarian, then authoritative, then overly permissive towards Andre. At some points she appeared to act protectively – confiscating weapons from him, but at other times she was less so and bribed Andre with rewards. One key reward for Andre was that his mother would agree to take him to a place which was known to be the key area where a gang was based, where professionals had assessed that there were significant risks for him. This was a source of concern for the professionals whose key role was to manage this risk and an indicator of concern regarding the effectiveness of the plans made.

37. Whilst practitioners observed and understood Andre's experience, the absence of a shared understanding of his mother's diagnosis might have offered further points for how to build a relationship with her, and some indication of what might and might not

have worked in terms of interventions to help her keep Andre safe. Several practitioners observed that although mother did engage and speak with professionals, her actions did not always evidence that she followed their advice, and they felt she may not have been able to, due to the deeply entrenched patterns in her relationship with her son and her fluctuating mental well-being. Practitioners were seeking to develop his mother's capacity to be a protective factor however did not fully understand the underlying factors in her behaviour  her poor mental health as the possible manifestation of her own experience of childhood adversity.

38. Andre's case was co-ordinated and managed through the local authority's High-Risk Panel (HRP). A concern was identified through the Rapid Review and amplified in further discussions around the lack of key information shared with or explored by the professional network either at the HRP or in Child Protection Conferences regarding the mother's history.  Practitioners reflected that this would have significantly impacted upon how professionals engaged with the mother. It would also have made very different a key aspect of the safety plan for Andre which was made at the HRP. The fact that the safety plan was based around the possible source of mother's own trauma had not been known although key details of this were known by one of the statutory agencies. There was enough evidence and information in the Child Protection system around this family to prompt curiosity about the underlying causes of this mother's presentation and how it might impact upon her children, even though at times, she provided adequate care to her children. However, it was identified by some agencies that there was a gap in the assessment of parenting.

***Learning point: To work effectively to support a parent in becoming a consistent protective factor where a young person is facing risk in the community, practitioners must understand the history, the trauma,  of the past risks and current vulnerabilities in the parent's life which contributes to their style of parenting. Curiosity is required regarding where observed behaviours come from. They should be discussed openly with the parent and reflected upon overtly as to how these factors might contribute to their parenting style.***

**Recommendation Two: The partnership needs to ensure that multi-agency assessments and planning of children include an assessment of parenting in that goes beyond the practical capacity  to provide care and explores the parent-child relationship in the light of the family's history of vulnerability and risk.**

**Part Three: Information regarding the new Children's Specialist Service established June 2021**

39. In the Rapid Review meeting and follow-up practitioner event, it became clear that there was both duplication and gaps in the parallel statutory processes managing the risk of Andre offending and the risk  of harm to Andre from familial and extra-familiar harm. Further inquiry has evidenced ongoing service development around the Children's Services' Adolescent Safeguarding service which works with young people who are  experiencing these different statutory processes.

40. On 14.12.2021, a conversation took placed with a small group of senior practitioners and managers of the new Enfield Adolescent Safeguarding Service, established in July 2021 and colleagues from Children's Services Assessment and Safeguarding teams. The National Panel suggested considering how the learning from practice in this case might support the development of their service. The focus of this inquiry was to ask what might be different in terms of intervention for a young person like Andre going forward?

41. There are two small adolescent safeguarding teams and a contextual safeguarding team within the service for which the case of Andre is particularly relevant. As well as social workers, there are youth workers, an embedded teacher and the Missing Co-ordinator. There are also close links to the Targeted Youth Support workers and a half time police post.

42. The service is still developing its delivery model and practice approach. Currently, cases come via a range of referral routes, and this is an area for developing and streamlining the route to the intervention in the service. Most workers in the service are new in role and therefore developing how they might intervene with individual young people, their families and in the communities that they live in. In the conversation there was there was evidence of some useful reflection about what the key objectives and challenges are for the service and of where the service could improve on what has been offered previously. A useful summary of what the challenge is: how can the service compete successfully with the *'offer'* from exploiters and gangs.

43. The identified approach was felt to be 'two-pronged' by working with the young person to fully grasp their lived experience and to work with the community to develop protective factors for young people – one example was given of the local football clubs as well as other sports. Practitioners in the conversation articulated their work with young people as 'relational', and that they needed to be open and honest to gain that in return from young people. Their role as workers appears to be multi-faceted: pro-actively enabling young people to access community opportunities, but also to work with young people to develop self-protection skills. Practical approaches offered included working with young people to recognise themselves and their experience, and to support the young person in identifying where the 'red lines' were for them in terms of the risks they faced. Working practices need to be flexible and creative to engage young people earlier and effectively.

44. This echoed the reflection on good practice by those that had worked with Andre as described in Part One of this review – it is suggested that all the practitioners working with the same cohort are offered regular opportunity to reflect and develop their practice approach together – YOS, education-based practitioners, and the new Adolescent Safeguarding service.

45. Evidence of strategic planning also emerged in terms of considering what the workforce in the service needed in terms of skills development but also partnerships with other organisations who could offer appropriate interventions. Therefore, the

adolescent safeguarding team were embedding evidence-based Edge of Care interventions and engaging with more local services such as a local provider of therapeutic mentoring as well as more widely offered schemes such as the Aspire programme offered by Transitions UK, as well as a Home Office offer of training in Cognitive Behavioural Therapy. The service manager also identified that the staff would be accessing clinical supervision to divert them from compassion fatigue and possibly developing secondary trauma.

46. It is clear that those in this conversation were thinking creatively and drawing on their experience about how the new adolescent service could be and the key is to begin to try and test the model out and develop a clear articulation of the offer from the service and the outcomes they wish to achieve for the young people, their families, and their community. Getting the identification, assessment and practice interventions right were identified by staff members as being key, as is a need to clearly defined roles and responsibilities with key colleagues and partners.

47. The service manager articulated several other areas that were the priority for development. Some of these were more practice based, for example where and how is early help offered. Andre had had no early intervention – his first service response from the multi-agency network were around exclusion and alternative school placement. Additionally, there is an identified need to work more effectively with siblings in families in order to avoid the development of the same vulnerabilities and repetition of the same risk in subsequent children in the same family.

48. We discussed some of the findings of the Rapid Review in terms of the duplication of structures and processes, another area of priority. The service manager felt that there is a need to improve upon the internal navigation of complex policy and procedures around contextual safeguarding – echoing the issues raised in this case regarding more effective applications of statutory tools to keep young people safe. The conversation identified a need to ensure strategic buy-in to support the changes needed and that these changes were a work in progress. The strategic management roles have been identified and the development of the framework needed is underway. The SCP should ensure a focus on these development over the next year.

49. The other two priorities mentioned were particularly relevant getting the information / intelligence sharing arrangements clear with those in practice confident about the status of information, from 'hearsay/gossip' to information as part of criminal inquiries and how it can be used. This is as relevant to individual cases as to the community/ context information around where the risks were coming from and where community interventions could be made to divert young people from violence. The other priority which lies beyond the team but is in the grasp of the partnership is to consider how resources can be accessed across the LA, schools, health and police

50. There was a recognition from those attending who had been involved regarding how complex Andre's case had been. The professional commitment and activity were there, the level of risk was understood, and the right interventions were in place, although the safety planning was not so well informed. Andre and his mother had

appeared engaged, Andre did talk and share with professionals and so there was a tangible hope that the plan to protect him would work. However, it is noted that the nature of engagement with parents with mental health issues is often hard to gauge – again, practitioners must reflect together on what 'real' engagement looks like with families. The evidence of engagement lies in the nature of the changes that families make to their ways, their patterns and their responses.

**Learning point: That relational practice with individual young people needs to sit within a strategic approach of developing community-based assets. The key to this is to ensure effective joint working strategically and operationally to address any potential obstacles regarding the basic of information sharing; shared service pathways; shared approach to engagement and interventions; shared priorities at different levels of need and risk. Some of this is in place and (anecdotally) is working well but there appear to be further improvements needed to ensure maximum impact.**

**Recommendation Three: Enfield Safeguarding Children Partnership ensure they have strategic oversight of the operational multi-agency arrangements for responding to this cohort of young people, who experience significant adversity and risk in different contexts. This should be a priority for the partnership in the forthcoming year and activity should include working with the safeguarding ambassadors to understand impact upon outcomes.**

**Recommendation Four: That Enfield Safeguarding Children Partnership ensure that the nature of engagement with families is reflected upon, and that effective engagement is evidenced in changes made in the family.**

**PART FOUR: System issues that have arisen during conversations**

51. An observation from the author was that whilst there was some excellent practice on an individual basis and from teams at the PRU and the YOS in working together, there is a sense that the structural challenges of disproportionality, racism and poverty experienced by black and mixed-heritage children works against positive outcomes for them and makes the experience of practitioners working in the system more difficult. One practitioner voiced his frustration at the gap between weak strategic planning and the reality of young people's lives as not tackling the real issues- e.g., addressing and rectifying the overuse of stop and search with young black people. It noted that since the practitioner event in November 2021, the Enfield Targeted Youth Engagement Board is focusing on Disproportionality across services in Enfield – this is a significant and relevant workstream to the learning from this review.

52. There was also some learning in terms of implementing review mechanisms when a child or young person dies which will be addressed through the partnership of ensuring that the difficult experience of some practitioners in attending the CDOP rapid response meeting very soon after Andre's death is not repeated. This has been addressed with the new CDOP lead as a practice improvement issue.

53. Other good practice areas in the system were identified: The Headteacher from the PRU identified that the SAFE panel was an excellent source of data but also supported

case direction. The PRU also has a social worker working full time with the children that attended and their families, who received her supervision from the Exploitation team based in the LA. This worker is able to ensure that prevention and effective early response is key to the offer to the children at the PRU.

54. It should also be noted that during conversations with the practitioners that it was clear that the interventions offered to Andre and his family during 2020-21 do not appear to have been impacted negatively by working within Covid restrictions. The YOS service spoke of finding new creative ways to do their work and fulfil their statutory functions; the social worker continued to visit the family home and the PRU did not close at all throughout any lockdowns – continuing to provide education and nurture to vulnerable young people throughout.

**Part Five: Conclusions and Recommendations**

Despite Andre's tragic death, the picture that emerges of the help and interventions he experienced prior to his death from a range of professionals is one of a committed and caring approach and much skill in their practice. After his death and through the Rapid Review process, agencies had reflected upon what they might have done differently in terms of responding to him and on how some systems and processes might not have been working as well as they could to co-ordinate interventions. Some of the changes identified as a result of this reflection were made swiftly. This review has led to some recommendations in the body of the report which are repeated below:

- **Recommendation One: Acknowledging and reflecting upon the elements of good culturally competent and anti-discriminatory practice is and how to embed it in safeguarding practice in Enfield should be a priority and focus for Enfield Safeguarding Children Partnership over the next year.**

- **Recommendation Two: The partnership needs to ensure that multi-agency assessments and planning of children include an assessment of parenting in that goes beyond the practical capacity to provide care and explores the parent-child relationship in the light of the family's history of vulnerability and risk.**

- **Recommendation Three: Enfield Safeguarding Children Partnership ensure they have strategic oversight of the operational multi-agency arrangements for responding to this cohort of young people, who experience significant adversity and risk in different contexts. This should be a priority for the partnership in the forthcoming year and activity should include working with the safeguarding ambassadors to understand impact upon outcomes.**

- **Recommendation Four: That Enfield Safeguarding Children Partnership ensure that the nature of engagement with families is reflected upon, and that effective engagement is evidenced in the changes made in the family.**